REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

A REVIEW OF THE STATE BOARD OF CONTROL'S VICTIMS OF CRIME PROGRAM

P-771 **MARCH 1988**

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Thomas W. Hayes
Auditor General

March 15, 1988 P-771

Honorable Bruce Bronzan, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 448
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the State Board of Control's Victims of Crime Program. This report determined that the Victims of Crime Program takes an average of 231 days to process claims submitted by victims incurring losses as a result of a crime, and does not deny, pay, or verify these claims accurately. Additionally, the Victims of Crime Program does not provide sufficient information to victims submitting claims and does not effectively use its automated system.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

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SUMMARY

RESULTS IN BRIEF

The State of California reimburses victims of crimes for medical care, wage loss, and other costs that result from the crimes. The State Board of Control (board) is responsible for processing victims' claims for reimbursements through the Victims of Crime Program (program) and, in 1987, approved or denied over 14,000 claims and paid claimants approximately $34 million. Most of the money to pay victims' claims comes from money collected from people convicted of crimes. During our review of the board for the period from July 7, 1987, through December 15, 1987, we noted the following deficiencies:

- The board does not process claims promptly. Current law requires the board to pay or deny claims within an average of 90 days and make disbursements of emergency awards within 30 business days. The board took an average of 231 days after the claims were accepted to process 100 regular claims that we reviewed and 49 business days to process the 35 approved applications for emergency awards that we reviewed;

- The board improperly denied, paid, or verified 27 percent of the 100 regular claims that we reviewed and made questionable denials on 13 of the 58 emergency award applications that we reviewed;

- The board does not inform claimants of the requirements for qualifying for emergency awards or for appealing staff decisions; and

- The board has poor internal control over the payments that are made from the board's automated tapes, and the

board does not use its automated system effectively to prevent duplicate payments or to monitor its payments to local agencies. This resulted in over $10,000 in payments to the wrong people and over $14,000 in duplicate payments.

BACKGROUND

The board administers the program, which reimburses victims of crimes for the cost of medical care and wage losses that result from the crimes. A claimant may submit a claim directly to the board or apply through a local victim witness center (local agency), which assists individuals in filling out claims and obtaining necessary documents. Some local agencies also verify the claim before sending it to the board.

PRINCIPAL FINDINGS

The State Board of Control Does Not Pay or Deny Claims Promptly

The board took an average of 231 days after the claims were accepted to pay or deny 100 regular claims that we reviewed. Present law requires that the board take only an average of 90 days after the claims are accepted to pay or deny claims. The board has been unable to pay regular claims promptly because local agencies take approximately four months to verify claims and because the board has not signed contracts with all local agencies for fiscal year 1987-88. In addition, the board does not have enough staff to process the number of claims that it receives, the board does not request necessary information promptly, and some of the board's procedures need to be streamlined. Because the board takes so long to reimburse claimants for their

losses, the board has unnecessarily subjected some claimants to financial hardship.

In addition, although the law requires the board to pay emergency awards within 30 business days, the board took an average of 49 business days to pay 35 emergency awards that we reviewed, and, as a result, some claimants suffered financial hardship. The primary reason that the board is not processing emergency award applications promptly is because staff members are taking time to verify the information on the applications for emergency awards even though board policy does not require them to do so.

The State Board of Control Improperly Denied, Paid, or Verified Claims

The board improperly denied, paid, or verified 27 percent of the regular claims that we reviewed. In addition, the board made questionable denials on 13 of the 58 claims for emergency awards that we reviewed. Consequently, eligible claimants did not receive reimbursement for costs that they incurred as a direct result of crimes.

The board paid $3,310 to ineligible claimants, overpaid eligible claimants $507, and underpaid eligible claimants $3,787 on the 100 regular claims that we tested. Also, the board made questionable payments totaling $30,303 to claimants and providers on the 100 regular claims that we tested because it did not always obtain required documentation and verification.

The State Board of Control Does Not Inform Claimants of the Requirements for Qualifying for Emergency Awards or for Appealing Staff Decisions

The board does not meet the requirements of the law because it does not explain to claimants how to qualify or apply for emergency awards. As a result, some claimants who should receive emergency awards either do not receive them or do not receive them promptly.

In addition, the board does not inform claimants that the board does not routinely hear individual cases, nor does it inform claimants that they must ask to be heard and appear in person at a board meeting if they want to appeal a staff decision. As a result, claimants who disagree with staff decisions often do not receive board hearings even though the staff decisions may have been made in error.

The State Board of Control Needs To Improve Its Internal Controls and Make Better Use of Its Automated System

The board has poor internal control over payments made from the automated tape that the board uses to make payments to claimants and providers. Consequently, the board has made erroneous payments. For example, in our review of 23 payments returned to the board, we found errors that resulted in payments to the wrong people totaling $10,332, and we found duplicate payments totaling $14,571. In addition, the board's automated system does not identify and prevent payments that exceed the maximum amount allowed by law.

Further, the board does not use its automated system effectively to confirm the accuracy of invoices from local agencies. For example, when a local

agency requests payment for verifying a certain number of claims, the board cannot ascertain whether the local agency actually verified that number of claims because its automated system does not keep a record of the number of claims that each local agency verifies for the board.

CORRECTIVE ACTION

The board's executive officer is implementing a number of measures to promptly pay or deny claims, improve the accuracy of the staff's work, and better inform applicants of the program's requirements and procedures. For example, the board is in the process of hiring additional staff, revising the claim application form, streamlining the board's procedures for verifying and making recommendations on claims, and modifying the computer system.

RECOMMENDATIONS

To ensure that claims are processed promptly and accurately, the board should take the following actions:

- Execute signed contracts with the local agencies that verify claims;
- Improve methods for obtaining information necessary for verification;
- Streamline some of the board's procedures for paying or denying claims; and
- Fill all authorized positions.

To ensure that claimants receive the necessary qualification information, the board should revise its claim application to clearly describe how an applicant can apply and qualify for an emergency award and advise claimants of their right to appeal board and staff decisions.

To ensure that it makes only authorized payments and to ensure that its automated files contain essential information, the board should take the following actions:

- Improve its internal controls over the automated tapes from which payments are made;

- Improve the automated system to identify and prevent duplicate payments and payments to claimants exceeding the amount allowed by law; and

- Require that staff members use the automated files to keep a record of the verified claims that they receive from each local agency.

Finally, the Legislature and the Governor should enact legislation that will establish an appeal process to ensure that claimants have the right to hearings if they disagree with staff recommendations.

AGENCY COMMENTS

The State Board of Control acknowledges that its processing of claims is not prompt or accurate, that claimants have not always received sufficient information, that its internal controls need improvement, and that it needs to make better use of its automated payment system. To correct these deficiencies, the board reports that it is drawing upon the resources of the State to assist in the review of its statutes and regulations, to develop new systems and forms, to write detailed processing procedures, and to automate the entire program. Within the next few months, the board expects to be processing claims within the 90-day average required by law.

INTRODUCTION

The State Board of Control (board) administers the Victims of Crime Program (program). The board consists of three members: the director of the Department of General Services, the state controller, and a third member who is appointed by the governor. An executive officer is responsible for the day-to-day operations of the board. Under the direction of the executive officer, a deputy executive officer with a staff of approximately 100 administers the program.

The purpose of the program is to reimburse victims of crimes for medical care, wage loss, and other costs such as funeral expenses that result from the crimes. The board approves or denies claims for several types of awards. The board may advance emergency awards up to $1,000 to victims with an immediate need who lose income or support or who require emergency medical care as a result of crimes. Also, the board processes claims for regular awards for claimants who are applying for the first time. The board can also approve or deny claims for additional awards on regular claims that have already been approved. (Appendix A presents the number of regular and additional claims paid or denied from fiscal year 1982-83 through fiscal year 1986-87.) Other awards approved by the board include "zero awards," which claimants apply for when their monetary losses that result from crimes have not yet been determined but the claimants want to establish their eligibility for reimbursement under the program. Claimants

eligible for reimbursement under the program include victims who are killed or injured as a result of crimes such as robbery or murder, in addition to anyone who is legally dependent on the victim of a crime for support.

An individual initiates a claim for assistance by applying directly to the board's Sacramento headquarters or through one of the victim witness centers (local agencies) located throughout the State that assist individuals in filling out applications and obtaining some documents such as the police report, medical bills, and pay stubs. Some local agencies then forward the claim to the board. Other local agencies also verify claims for the board before sending them to the board. The staff at either the board or local agency verify the claims by obtaining additional documents, including physicians' medical evaluations that confirm disability periods. Staff may also verify the accuracy of claimants' losses by telephoning physicians, insurance companies, and the claimants' employers. Once a claim is verified by either the local agency or board staff, board analysts and claim specialists prepare a list of recommendations on claims that staff will present to the board during a hearing, which the board holds approximately every two weeks. The board notifies claimants by mail of these recommendations.

The board has two hearing agendas. The "consent" agenda lists claims that the board members agree to pay or deny according to the staff's recommendations without any review or discussion. This agenda

typically contains 91 percent of all claims that the board denies or pays. The board's "discuss" agenda consists of claims the board may review and discuss. The board discusses a claim if the claimant attends the hearing or if staff have not made a recommendation on a claim. In 1987, the board paid or denied a total of 14,230 claims, 12,879 claims on the consent agenda and 1,351 claims on the discuss agenda. In 1987, the board paid approximately $33.9 million to claimants and their providers. The board pays victims' claims with money collected from people convicted of crimes.

The board employs two managers to supervise the staff members who verify and review the eligibility of claims. The board employs approximately 10 claim analysts, 5 supervising claim specialists, 4 senior claim specialists, and 45 claim specialists. Some local agencies function as contractors to the board, and these agencies employ their own verification staff. However, the board determines a compensation schedule for the agencies based on a formula that establishes the number of employees each agency will need to process the minimum number of claims that the agency has agreed to process each year.

SCOPE AND METHODOLOGY

The Office of the Auditor General conducted this audit to determine whether the board paid or denied victims' claims promptly, accurately, and according to consistent criteria. In addition, we

reviewed the board's computer system to determine whether the board has sufficient controls over claim payments that the board makes through the computer system and to determine whether the information in the computer system is accurate and complete.

To determine whether the board paid or denied claims promptly and accurately, we reviewed 100 of 4,637 regular claims appearing on the board's consent agendas between July 7, 1987, and December 15, 1987. We also reviewed the board's hearing process. In addition, we reviewed 60 claims for emergency awards that the board paid or denied during the same period. However, the board erroneously classified one of the claims in the sample of 60 as a claim for an emergency award. In addition, the board could not find the file for another claim for an emergency award. As a result, we only tested 58 claims for emergency awards. We also obtained a listing of regular claims that the board received during the month of October 1987 and identified which of these claims the board had paid or denied as of January 31, 1988.

CHAPTER I

THE STATE BOARD OF CONTROL DOES NOT PAY OR DENY CLAIMS PROMPTLY

The State Board of Control (board) is not paying or denying regular claims within the time limits required by law. From the date that the board or a victim witness center (local agency) accepted the claims that we reviewed, it took an average of 231 days to pay or deny them. Present law requires that the board take only an average of 90 days to pay or deny regular claims. By taking so long to reimburse claimants for their losses, the board has unnecessarily subjected some claimants to financial hardship. For example, a claimant reported that he was unable to pay his rent, and, consequently, his landlord was threatening him with eviction. The board has been unable to promptly pay regular claims because local agencies are taking approximately four months to verify the claims, the board has not signed all contracts with local agencies for fiscal year 1987-88, the board has not had enough staff to process the number of claims that it has received, the board does not always request necessary information promptly, and some of the board's procedures need streamlining. Currently, the executive officer is implementing a number of measures to correct these deficiencies. In addition to not paying or denying regular claims promptly, the board is taking approximately 49 days to pay emergency awards although the law limits this time to 30 business days. The primary reason for this delay is that staff members are taking time to verify the information on the applications for the emergency awards even though board policy does not require them to do so.

REGULAR CLAIMS

Recent legislation significantly reduced the amount of time by which the board must pay or deny regular claims. Since September 27, 1987, Section 13962(b) of the Government Code has required the board to pay or deny a regular claim within an average of 90 days from the date that the board or local agency accepts the claim.[1] Before September 27, 1987, the code required the board to pay or deny a claim within 90 days from the date that the board accepted the claim as fully verified. Thus, the old law did not require the board to include in the 90-day limit the time that it took to verify the claim. The new law requires the board to include verification time in the average of 90 days that the board should take to pay or deny a claim.

However, the board is not meeting either the old or the new time limit specified in the law. We reviewed 100 regular claims that the board paid or denied between July 7, 1987, and December 15, 1987. The board took an average of 100 days to pay or deny these claims from the date that either board staff completed verifying the claims or the board received the claims verified by local agencies. The board took

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[1]Section 6806 of the Government Code defines a day as midnight one day to midnight the next day. The measurement of the amount of time that the board must pay or deny regular claims is in calendar days. For emergency awards, the law requires the measurement in business days.

an average of 231 days to pay or deny these claims from the date that either board staff or local agencies accepted the claims. In Table 1, we show how many days the board took to process the 100 claims, using the time limit established by the old law as well as the new.

TABLE 1

THE NUMBER OF DAYS THAT THE BOARD TOOK TO PAY OR DENY A SAMPLE OF 100 REGULAR CLAIMS

	Number of Claims	
Days	Old Law	New Law
0 to 50	40	
51 to 90	16	7
Total Within Law	56	7
91 to 180	31	36
181 to 270	7	32
271 to 450	5	18
451 to 570		3
571 to 750	1	3
751 to 850	—	1
Total Late	44	93

Because the new law took effect during the period that we reviewed, we also attempted to measure the amount of time that the board took to process the claims that it received after the new law

took effect.[2] The board accepted 1,601 claims in October 1987. However, we could not determine the average number of days that it took the board to pay or deny all of the 1,601 claims because, as of January 31, 1988, staff had paid or denied only 16 percent of these claims. Table 2 illustrates the status of each claim acknowledged in October 1987, as of January 31, 1988.[3]

TABLE 2

STATUS OF REGULAR CLAIMS ACKNOWLEDGED IN OCTOBER 1987 AS OF JANUARY 31, 1988

Status	Number of Claims	Percent of Total Claims
Claims paid or denied	264	16%
Claims scheduled for a board hearing	9	1
Claims being worked on by board staff	555	35
Claims waiting for staff to begin work	741	46
Unable to determine status	32	2
Total Claims	1,601	100%

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[2]The board received all but one of the 100 claims that we reviewed before September 27, 1987, when the new law became effective.

[3]Upon receipt of the completed application, the board sends an acknowledgment letter to the victim, notifying the victim that the claim has been accepted.

We believe that the board's current processing time is the same or probably greater than the average time we calculated for our sample of claims for the last six months in 1987. As Appendix B shows, from January 1987 through January 1988, the board has accepted 6,081 more claims than it has paid or denied. Consequently, the size of its backlog of unprocessed claims has steadily increased, which may tend to increase the amount of time that the board took in February 1988 to pay or deny claims.

Effects of Delaying Payments for Regular Claims

Delays in payments cause financial hardship for claimants. For example, one claimant in our sample was disabled during August 1986 as a result of an assault. The local agency accepted his claim on December 5, 1986, but the claimant then had to wait 231 days until the board finally paid his claim on September 8, 1987. During that time, the claimant wrote five letters to the board. His fourth letter, dated July 14, 1987, stated that he might be evicted from his apartment. Further, the claimant's landlord wrote to the board on August 25, 1987, stating that the claimant owed $1,096 in rent.

Late payments also penalize providers who supply services to claimants. For example, the executive director of one company that provides services to victims stated in a letter to the board that the company had a debt of over $300,000 while waiting for reimbursement from the board. The letter specified that the continued existence of

the company was in jeopardy, and that, if cash flow did not improve within three to four months, the company would be faced with closure.

The Board's Process for Reviewing Claims

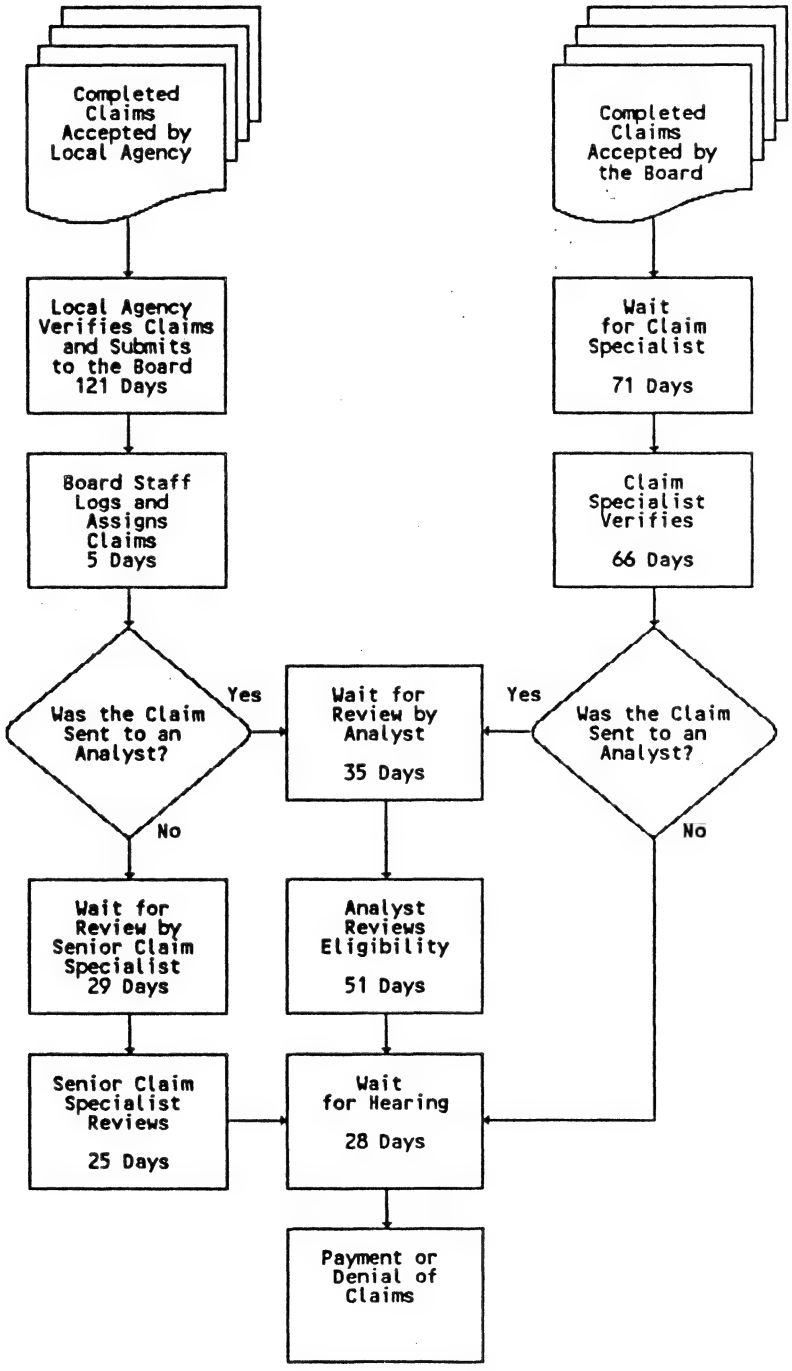
Claimants file claims either through the board's office in Sacramento or with one of the local agencies located throughout the State. According to the board's contract manager, in fiscal year 1987-88, 24 of the local agencies verified the claims that they received and forwarded the verified claims to the board. Other local agencies forward the claims that they receive to the board for its staff members to verify.

At the board, claim specialists verify all unverified claims that are submitted. Claim specialists place verified claims that are for less than $3,000 and that clearly meet the board's eligibility requirements on the board's consent agenda. The claim specialist must send all other claims, including claims that clearly do not meet the board's eligibility requirements and that the board will deny, to an analyst. Claim specialists routinely send claims called "zero awards" to analysts. A claimant applies for a zero award when his or her monetary losses that result from a crime have not yet been determined, but the claimant wants to establish his or her eligibility for reimbursement under the Victims of Crime Program.

Claims verified by local agencies go to senior claim specialists for review if the claims are less than $3,000 and do not involve any factors that bring their eligibility into question. The senior claim specialists can recommend payment on properly verified claims, and these claims are placed on the board's consent agenda. All other claims that local agencies have verified must go to analysts for review. Analysts evaluate these verified claims to recommend whether the board should pay, deny, or discuss them. Illustration 1 shows the major stages in the process of paying or denying claims. For the 100 regular claims in our sample, it also shows the average number of days that claims spent at applicable stages.

ILLUSTRATION I

ILLUSTRATION OF THE CLAIMS PROCESS INCLUDING THE AVERAGE NUMBER OF DAYS THAT THE 100 CLAIMS WE REVIEWED WERE DELAYED AT APPLICABLE STAGES



Delays at the Local Agencies

For the 52 claims (52 percent) in our sample that were verified by local agencies, local agencies took an average of 121 days to verify a claim from the date that the local agency accepted the claim to the date that the board received the verified claim. Although we did not visit any local agencies, we determined that the local agency for Los Angeles County was having difficulty promptly verifying claims partially because of lack of staff. Of all the local agencies, this agency verifies the most claims. The board's contract for fiscal year 1986-87 required the agency to verify 4,500 claims, which constituted 50 percent of the total minimum number of verifications for which the board had contracted with the local agencies. However, the board does not have a written contract with the local agency for Los Angeles County for fiscal year 1987-88. In fact, as of January 1988, the board had not executed a signed contract with 23 of 24 local agencies that verify claims, but the board has continued to accept verified claims from these local agencies. According to the executive officer, the board had not signed the contracts because of concerns about the "form and enforceability" of the contracts that the board had used in fiscal year 1986-87. Since the board may not pay these agencies in the absence of a contract approved by the Department of General Services, the board has not paid the local agency for Los Angeles County for verifying any claims in fiscal year 1987-88. Because the board did not execute a written contract for fiscal year 1987-88, the Board of Supervisors for Los Angeles County has refused to authorize any new positions for verification staff at the local agency.

The board has indicated that it wants the local agency for Los Angeles County to verify 8,000 claims in fiscal year 1987-88, a 3,500 claim increase over the 4,500 claims that the agency contracted to verify in fiscal year 1986-87. According to the board's staffing formula, the agency needs several more positions than it had in 1986-87. According to a representative for the local agency, as of February 18, 1988, the agency had 1,388 claims over 60 days old and 1,435 claims under 60 days old. We believe that the local agency would not have as large a backlog if the agency had been able to hire additional staff.

Delays During Verification at the Board

Board claim specialists verified 48 (48 percent) of the claims in our sample. Claim specialists took an average of 137 days to verify these claims. Of that total time, claims were held an average of 71 days in a pending file until the claim specialists began working on them. Once the claim specialists began their work, they took an average of 66 days to verify the claims.

Lack of staff contributed to the delay in verifying claims at the board. From July through December 1987, the number of unprocessed, regular claims held by the board increased by 3,437 claims. During that same period, the board could not obtain the staff that it needed to process all the claims that it received.

In December 1986, the board requested that the fiscal year 1987-88 budget include funding for 13 additional staff members. Further, the Department of Finance in March 1987 requested for the board 28 temporary positions and 21 additional permanent positions. The Department of Finance requested the additional staff for the board because of a 30 percent increase in the number of claims actually received over the number anticipated. The 1987-88 budget, approved on July 7, 1987, included money for these 49 additional employees; however, because of a projected shortage in the program's funding, the Legislature, when it approved the budget, prohibited the board from spending the money unless legislation was enacted that increased revenue for the program. This legislation was enacted on September 27, 1987. According to the executive officer, the board has since had to secure space for the new positions and develop a list of candidates. The board intends to hire some of the candidates by the end of March 1988.

According to the executive officer, some delays occur in the verification stage of claim processing because claim specialists do not request information necessary for verification as soon as a claim is received. For example, we noted in our sample of claims that a claim specialist had initially reviewed one of the claims on January 16, 1987. Although the claimant requested reimbursement for counseling expenses stemming from a rape and robbery, the claim specialist did not request the necessary documentation from the

therapist until 199 days later, on August 3, 1987. The therapist supplied the documentation 31 days after the claim specialist sent the request.

The executive officer said that partially to reduce the delay caused by staff members not sending requests for information as soon as a claim is received, the board instituted a new procedure on January 25, 1988. On specified days, claim specialists will review all pending claims and send requests for information immediately. According to the executive officer, as of February 18, 1988, the board had sent requests for necessary information for approximately 1,610 claims.

In addition, the executive officer said that the board believes some delays occur in verifying claims because instructions on the claim application do not provide enough information to the claimant. Claimants, therefore, submit incomplete applications that delay processing while the claim specialist obtains the proper documentation. The executive officer said that as a result of this problem with the claim application, the board has formed a task force to create a new application form. Also, the board formed another task force that has designed a process to determine, immediately upon receipt, whether an application is complete. During the initial phase of the review, the task force found that 68 percent of the applications received from claimants who were not assisted by either an attorney or a victim witness center were incomplete. To reduce this rate of

incomplete applications, the board has concluded that among other things, the board needs to clarify the instructions on the claim application.

Delays During the Analysts' Review

The 59 regular claims in our sample that analysts eventually reviewed were held an average of 35 days before being assigned to the analysts for review and were held 51 days before the analysts recommended that the board pay, deny, or discuss them. For many of the claims in our sample, an analyst attributed delays in processing at the analyst stage to analysts having a backlog of claims to review. However, we found that the board's procedures require analysts to review more claims than necessary. For example, in addition to claims for more than $3,000 and ones that require further discussion, analysts must also evaluate and recommend an appropriate action for all claims for zero awards. Since a claim for a zero award does not involve the approval or denial of any payment, it could probably be left to the claim specialists and senior claim specialists to review. The board granted 1,764 zero awards in 1987. If analysts had not reviewed the claims for these zero awards, they would not have had such a large backlog.

The executive officer stated that the board currently questions the efficiency of procedures that require analysts to review so many categories of claims, particularly zero awards, denials, and

all claims over $3,000. According to the executive officer, the board has begun designing and implementing faster, more efficient procedures for verifying and making recommendations on claims. The procedures will reduce the number of claims reviewed by analysts.

Delays Between Recommendations and the Board Hearings

For the claims in our sample of regular claims, an average of 28 days elapsed between the date that the staff recommended a decision on the claim and the date of the hearing at which the board approved or denied the claim. Typically, the board's consent agenda contains 91 percent of all the claims that the board denies or pays. Consequently, for most of the claims that the board pays, a portion of the delay between the staff decision and a board hearing is unnecessary. The board could eliminate some of this delay if, immediately after staff recommended a decision on a claim for the consent agenda, the board paid the claim rather than waiting for a formal approval from the board at a hearing. To do this, however, the law will need to be changed. Section 13963 of the Government Code requires that the board review each claim at a hearing. Currently, the board formally approves every payment or denial of a claim at a board hearing. The board typically holds two hearings each month. Board members accept staff members' recommendations to pay or deny claims that appear on the consent agenda without any additional review or

discussion. The Government Code should be changed to allow the board to delegate to the executive officer the authority to pay claims without a hearing by the board.

EMERGENCY AWARDS

Section 13961.1(c) of the Government Code requires that the board pay emergency awards within 30 business days of receiving the claim. The Government Code also allows the staff to use 10 extra days to review the application if the claimant authorizes the extension. Section 13961.1(c) of the Government Code allows the board to delegate the granting of emergency awards to staff members. However, the board paid only 4 (11 percent) of the 35 paid emergency awards in our sample within 30 business days. The board required an average of 49 business days to pay the 35 paid claims in our sample. Further, we could find no evidence that the board had requested claimants' permission to extend the processing period for the claims in our sample. Table 3 shows the number of days that the board took to pay 35 of the emergency awards in our sample.

TABLE 3

THE NUMBER OF DAYS THAT THE BOARD TOOK TO PAY A SAMPLE OF 35 EMERGENCY AWARDS

Business Days from Application to Payment	Number of Claims
0 to 20	
21 to 30	4
Total Within Law	4
31 to 40	10
41 to 60	13
61 to 90	7
91 to 180	1
Total Late	31

Effects of Delaying
Payments for Emergency Awards

Claimants experience hardship because they do not receive emergency awards promptly. For example, because the board did not pay her emergency award until 43 business days after she submitted it, one claimant in our sample had to borrow money to pay funeral expenses for her brother who was murdered.

Reasons for Delays in
Paying Emergency Awards

The board delays payments because staff members verify information rather than rely on claimants' certification. According to the law and to board memorandums, the board can approve claims for emergency awards without verifying the information. (See Chapter II for a more detailed discussion of this problem.) In addition, the board delays payments by approving or denying emergency awards at board hearings even though the law allows the board to delegate such decisions to staff members. For the claims in our sample, an average of 13 days elapsed between the date that the staff members made a recommendation and the date that the board allowed or denied the claim.

CONCLUSION

The State Board of Control does not promptly process claims from victims of crimes for reimbursement of losses due to injuries sustained from the crimes. As a result, some claimants suffer unnecessary financial hardship. The board has contributed to the processing delays of regular claims at the local agency for Los Angeles County, which verifies the most claims of any local agency, because the board failed to execute a signed contract with the county. Further, lack of staff at the board has added to delays for regular claims. The board received funding for more staff in September 1987. Also, according to the board's executive officer, the board

does not always request necessary information from a claimant upon receipt of the claim. In addition, the claim application does not clearly instruct the claimant about the information necessary to include with the claim. Furthermore, the board has contributed to delays by requiring that analysts review more claims than necessary. Moreover, the required hearing of each claim by the board delays claims unnecessarily. In addition to delays in processing regular claims, the board delays payment of emergency awards. The primary reason for this delay is that staff members are taking time to verify the information on the applications for the emergency awards even though board policy does not require them to do so.

RECOMMENDATIONS

To process claims promptly, the State Board of Control should take the following actions:

- Execute signed contracts with the local agencies that verify claims;

- Fill all authorized positions for the Victims of Crime Program;

- Ensure that staff members who verify claims request necessary information promptly for paying or denying claims;

- Ensure that the claim application provides clear instructions regarding how to submit a complete claim;

- Reduce analysts' workload by not routinely requiring analysts to review claims for which analysts' evaluations are unnecessary; and

- Delegate the approval or denial of emergency awards to staff members.

To accelerate the payment of regular claims, the Legislature and the Governor should amend the current law to allow the board to delegate to the executive officer the authority to pay claims without a hearing by the board.

CHAPTER II

THE STATE BOARD OF CONTROL IMPROPERLY DENIED, PAID, OR VERIFIED CLAIMS

The board improperly denied, paid, or verified 27 percent of the regular claims that we reviewed. The board improperly denied 5 of 100 regular claims that we reviewed and one of the 58 claims for emergency awards that we reviewed and made questionable denials on 13 of the 58 claims for emergency awards that we reviewed. As a result, eligible claimants did not receive reimbursement for costs that they incurred as a direct result of crimes. In addition to the claims that the board improperly denied, the board paid $3,310 to two ineligible claimants, overpaid five eligible claimants $507, and underpaid four eligible claimants $3,787 on the 100 regular claims that we tested. Finally, we estimate that the board made 13 questionable payments totaling $30,303 to claimants and providers on the 100 regular claims that we tested because board staff did not always obtain required documentation and verification.

Using the criteria specified in the Government Code, Sections 13959 through 13974, the instructions specified in the board's Verification Training and Reference Manual, and relevant policy and procedure memos of the board, we tested the accuracy of the claim verification process performed for each of the claims in our sample.

REGULAR CLAIMS

We selected a sample of 100 of the 4,637 regular claims that board staff processed and placed on the board's consent agendas between July 7, 1987, and December 15, 1987. In addition, we reviewed 38 "related" claims. Related claims are either submitted by different victims of the same incident or by the same victim for different incidents. The board paid claimants a total of $152,816 on 81 claims in the sample of 100 and denied the remaining 19 claims.

Errors in Denial

The board improperly denied 5 (26 percent) of the 19 denied claims in our sample. Two of these 5 denials were improper because staff incorrectly determined that the claimants were ineligible. The other 3 were improperly denied because staff did not place these claims on the board's discuss agenda as board policy requires. However, we could not determine the total amount that claimants should have received on these 5 claims because board staff denied these claims before they completed verifying the claimants' expenses resulting from the crimes. Table 4 describes the specific denial errors that we found.

TABLE 4

ERRORS MADE IN THE IMPROPER DENIAL OF 5 CLAIMS FROM A RANDOM SAMPLE OF 19 DENIED CLAIMS

Claim Sample Number	Criteria	Error Made by the Board	Type of Assistance Claimed
3, 37, 62	Victims of Crime Program Policy and Procedure Memorandum dated April 22, 1987, requires board discussion of all claims in which there are no criminal complaints filed against a suspect.	The analysts denied the claims without board discussion even though the claims stated that no criminal complaints were filed against the suspects.	Medical
12	Section 13959 et seq. of the Government Code allows victims reimbursement for losses they suffer as a direct result of criminal acts.	The claim specialist did not approve therapy expenses for a molested minor because her mother, upon the advice of the claim specialist, filed a claim for only one of three incidents. This incident did not result in injuries from a criminal act although the other two incidents did.	Psychotherapy
73	Section 13964 of the Government Code states that an application cannot be denied solely because no criminal complaint has been filed or because a criminal complaint is filed but later dismissed, unless the victim knowingly and willingly participated in the commission of the crime or the victim did not cooperate with law enforcement.	The claim specialist did not approve therapy expenses for a molested minor because her mother did not file criminal charges, and the claim specialist, therefore, concluded that the victim had not cooperated with law enforcement.	Psychotherapy

Error Rate - 26%

In one instance, a staff analyst had denied a claim for therapy for a child suffering from the emotional trauma resulting from molestation. The analyst denied the claim because the victim's mother failed to contact law enforcement regarding the investigation of the suspect in the case, and, as a result, no charges were filed against the suspect. However, the Government Code, Section 13964, specifies that no application can be denied solely because no criminal complaint has been filed unless the victim contributed to the crime or unless the victim failed to cooperate with law enforcement. In this case, the board had no evidence that the victim contributed to the crime, and the victim's mother, not the victim herself, was the person who failed to contact law enforcement.

In another example, the claimant filed for therapy necessary to alleviate the psychological trauma resulting from child molestation. However, because the victim's mother was misinformed by a local agency representative verifying the claim, she did not file the claim for the dates on which the child molestation occurred. Instead, she was instructed by a local agency representative to file a claim for her child's most recent encounter with the suspect in the case, yet the child's most recent encounter did not involve molestation. When the local agency representative submitted this claim to board headquarters, the analyst reviewing the claim returned the claim to the local agency, informing the agency representative that the claim must be filed for the dates on which the child molestation occurred.

The claim verification report prepared by the local agency showed the actual dates of the crimes. However, the local agency representative did not correct the date of the crime on the claimant's application and returned the original claim application to board headquarters, explaining that she believed that she completed the application in accordance with the instructions she received during training. When the agency representative returned the claim to board headquarters, the same analyst who reviewed the claim the first time denied the claim because injuries did not result from the crime that occurred on the specific date for which the claim was filed. According to a board analyst, board headquarters staff did not directly inform the claimant that she should file her claim for the dates on which the child molestation occurred because the local agency representative is obligated to relay all additional information to the claimant. However, in this case, the analyst reviewing the claim was aware that the local agency representative verifying the claim did not relay this information to the claimant. The psychological evaluation of the victim in this case specified that, for the victim to reach or exceed her previous level of functioning, she would require therapy for 18 to 30 months at a cost of $13,000. The victim's mother had no insurance to finance her child's therapy.

Claim Overpayments

In addition to improperly denying claims, the board made overpayments on 8 (10 percent) of the 81 paid claims that we reviewed. Specifically, the board paid two ineligible claimants a total of $3,310, and five eligible claimants $507 more than they should have received. The total overpayments, $3,817, represent 2 percent of the total amount paid on all of the claims that we reviewed. Table 5 describes the specific errors of the board when it paid ineligible claimants, and Table 6 describes the specific errors of the board when it overpaid eligible claimants.

TABLE 5

ERRORS MADE IN THE PAYMENTS TO TWO INELIGIBLE CLAIMANTS OR THEIR PROVIDERS FROM A RANDOM SAMPLE OF 81 APPROVED CLAIMS

Claim Sample Number	Criteria	Error Made by the Board	Amount of Overpayment
53	Section 13964 of the Government Code specifies that no victim shall be reimbursed if he or she knowingly or willingly participates in the commission of the crime.	The claim specialist allowed the claim even though the victim appears to have contributed to the crime by becoming intoxicated and complying with the request of two strangers who motioned for him to come outside.	$ 764
64	Section 13964 of the Government Code requires the board to approve a claim if most of the evidence shows that, as a direct result of the crime, the victim incurred an injury that resulted in a loss for which the victim has not and will not be reimbursed.	The claim specialist allowed the claim even though the police department reported that it had no record that a crime had occurred.	2,546
			$3,310

Error Rate - 2%

TABLE 6

ERRORS MADE IN THE OVERPAYMENTS TO FIVE ELIGIBLE CLAIMANTS OR THEIR PROVIDERS FROM A RANDOM SAMPLE OF 81 APPROVED CLAIMS

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount of Overpayment
46	Section 13960, together with Section 13965, of the Government Code specifies that a reimbursement must be for an expense for which the victim has not and will not be reimbursed from any other source.	The board reimbursed the provider for an amount that the claimant did not owe because the amount billed to the claimant was merely a suggested donation.	$ 80	$ 80
49	The board's Verification Training and Reference Manual provides a table for converting gross wage losses to net wage losses based on annual income.	The claim specialist converted gross wages to a net wage loss based on the loss period income.	242	28
50	Section 13960, together with Section 13965, of the Government Code authorizes payments for burial expenses only to individuals who legally assume the obligation or pay for the expenses.	The claim specialist approved burial expense payment to the claimant even though another person paid these expenses.	676	53

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount of Overpayment
88	Section 13960, together with Section 13965, of the Government Code specifies that, to qualify for reimbursement, a wage loss has to be greater than $100 or greater than or equal to 20 percent of the victim's net monthly income, whichever is less, except for victims who are on fixed income from retirement or disability.	The claim specialist converted gross wages to a net wage loss that was less than $100 and less than 20 percent of the victim's net monthly income.	260	80
92*	Section 13960, together with Section 13965, of the Government Code specifies that victims can only be reimbursed for expenses incurred as a direct result of the crime.	The claim specialist approved reimbursement of medical expenses that were not related to the crime.	266	266
			$1,524	$507

Error Rate - 6%

* A related claim to this claim appears on Table 8. The related claim was part of the sample and was also potentially reimbursed in error.

In one instance of payment to an ineligible claimant, the board paid the claimant $2,546 for medical expenses and lost wages resulting from a gunshot wound. According to the claim verification report in the claim file, the claimant described the incident by stating that he was walking into a store and felt a pain in his leg that "turned out to be a gunshot wound." The Government Code, Section 13964, requires the board to approve a claim if a preponderance of the evidence shows that, as a direct result of a crime, the victim incurred an injury that resulted in a loss. However, in this case, when the claim specialist processing this claim attempted to contact the police department to verify whether a crime had occurred, she was informed by the police department that it had no record of a police report for the incident for which the claim was filed. In addition, there was no evidence in the claim file that indicated that the claim specialist verifying the claim or the analyst who approved payment on the claim ever performed further investigation to determine whether a crime had occurred and whether the victim was eligible for reimbursement.

Claim Underpayments

In addition to overpayment of claims, the board underpaid four eligible claimants in our sample a total of $3,787. Table 7 describes the specific underpayment errors that we found.

TABLE 7

ERRORS MADE IN THE UNDERPAYMENTS TO FOUR ELIGIBLE CLAIMANTS OR THEIR PROVIDERS FROM A RANDOM SAMPLE OF 81 APPROVED CLAIMS

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount of Underpayment
41	Section 13960, together with Section 13965, of the Government Code, authorizes payment for wage loss incurred as a direct result of an injury.	The claim specialist did not include the entire disability period in the wage calculation so that the claimant was not paid for the entire wage loss incurred as a direct result of an injury.	$13,279	$3,164
48*	The board's Verification Training and Reference Manual provides a table for converting gross wage losses to net wage losses and instructs the user to round down the percentage to deduct from gross wages in favor of the victim.	The claim specialist converted gross wages to a net wage loss by rounding up the percentage deducted from gross wages to the next highest conversion factor.	1,011	6
82	The board's Verification Training and Reference Manual provides a table for converting gross wage losses to net wage losses and instructs the user to round down the percentage to deduct from gross wages in favor of the victim.	The claim specialist converted gross wages to a net wage loss by rounding up the percentage deducted from gross wages to the next highest conversion factor.	2,851	117

* This claim also appears on Table 8 because the applicant filed for reimbursement of mental health expenses and wage loss and both reimbursed amounts were in error.

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount of Underpayment
86	Section 13965 of the Government Code authorizes payment of attorneys' fees for legal services rendered to the applicant.	The board did not approve payment of attorneys' fees because staff failed to enter the payment in the computer system before the hearing, and this failure caused the payment to be omitted from the board hearing agenda.	9,397	500
			$26,538	$3,787

Error Rate - 5%

In one case of underpayment, a claimant was underpaid $3,164 for lost wages because the analyst who calculated the lost wages erroneously used the date that the claimant's state disability reimbursement was exhausted as the ending date of the claimant's disability period. However, the claimant lost his job as a result of his disability, and the claimant's physician provided documentation that specified that the claimant's actual disability period extended 46 days beyond the date that the claimant's disability reimbursement was exhausted. The analyst calculated the claimant's lost wages until the date that his state disability was exhausted because she stated that she could not contact the claimant to instruct him to provide information concerning whether he had obtained a new job. However, our review found no evidence in the claim file that the claimant was contacted and instructed to submit additional information, and the analyst already had a medical physician's statement concerning the claimant's disability period. The board's Verification Training and Reference Manual specifies that a disability statement can be accepted from a licensed medical physician.

In another case of underpayment, the board did not pay $500 in attorney fees for one claim simply because board staff neglected to place that payment on a hearing agenda. The Government Code, Section 13965, allows the board to pay fees to attorneys for the reasonable value of any legal services they provide when assisting a claimant in submitting a claim application.

Errors in Documentation and Verification of Claims

In addition to making overpayments and underpayments, staff members do not always obtain the proper documentation and verification before they recommend the payment of claims. Table 8 describes the specific documentation and verification errors that we found.

TABLE 8

ERRORS IN DOCUMENTATION AND VERIFICATION FOR 13 CLAIMS FROM A RANDOM SAMPLE OF 81 APPROVED CLAIMS

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount Potentially Overpaid
4	Victims of Crime Program Policy and Procedure Memorandum dated April 22, 1987, requires board discussion of all claims in which there are no complaints filed against a suspect.	The claim specialist approved the claim without board discussion when the claim stated that no complaint was filed against the suspect.	$ 1,962	$ 1,962
5	The board's Verification Training and Reference Manual requires board staff to obtain written notification of application withdrawal requests.	The claim specialist did not obtain the claimant's request for withdrawal of an application in writing.		
9	Section 13965 of the Government Code authorizes payment of attorneys' fees for the reasonable value of legal services rendered to the applicant not to exceed 10 percent of the award, or $500, whichever is less.	The claim specialist approved payments to an attorney for four related claims without determining the reasonable value of legal services rendered to the applicant and merely paid the maximum allowable.	5,544	504
48*	Victims of Crime Program Policy and Procedure Memorandum dated July 10, 1986, requires the claim specialist to obtain a mental health evaluation if mental health expenses are expected to exceed $1,000.	The claim specialist approved mental health expenses without a mental health evaluation when expenses were expected to exceed $1,000.	1,011	945

* This claim also appears on Table 7 because the applicant filed for reimbursement of mental health expenses and wage loss and both reimbursed amounts were in error.

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount Potentially Overpaid
51	Section 13966 of the Government Code entitles the State to a claim on restitution amounts recovered by the victim in the future.	The claim specialist did not file for recovery of restitution, which the court had ordered the criminal to pay.	1,480	1,480
65	Section 13962 of the Government Code authorizes the board to obtain verification of any reimbursements that the victim might have already received from other sources.	The claim specialist did not obtain life insurance verification when a claimant's insurance benefits might have covered funeral costs paid by the board.	2,649	2,649
69	Section 13962 of the Government Code authorizes the board to obtain verification of any reimbursements that the victim might have already received from other sources.	The claim specialist did not obtain liability insurance verification when a claimant's insurance benefits might have covered mental health expenses paid by the board.	1,170	1,170
	Section 13966 of the Government Code entitles the State to a claim on amounts recovered by the victim in the future.	The board did not file a claim against future recoveries in a possible civil action.		
70	Section 13962 of the Government Code authorizes the board to obtain verification of the costs of medical treatments received by the victim.	The claim specialist did not obtain proper medical verification for medical expenses paid by the board.	745	222

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount Potentially Overpaid
	Section 13966 of the Government Code entitles the State to a claim on amounts recovered by the victim in the future.	The board did not file a claim for recovery of restitution, which the court had ordered the criminal to pay.		523
74	Victims of Crime Program Policy and Procedure Memorandum dated July 10, 1986, requires the claim specialist to obtain a mental health evaluation if mental health expenses are expected to exceed $1,000.	The claim specialist approved mental health expenses without a mental health evaluation when expenses were expected to exceed $1,000.	960	960
76	Section 13964 of the Government Code specifies that no victim shall be reimbursed if he or she knowingly or willingly participates in the commission of the crime, and the board's Verification Training and Reference Manual requires claim specialists to note on the claim verification report any evidence of possible contribution to the crime.	The claim specialist allowed the claim even though there was evidence that the victim had possibly contributed to the crime by complying with the suspect's offer to "step outside" and by later getting out of his vehicle to involve himself in a wrestling match with the suspect. The claim specialist did not note on the claim verification report the evidence of possible contribution to the crime.	866	866
84	Section 13962 of the Government Code authorizes the board to obtain verification of amounts received by the victim that were related to the crime.	The claim specialist did not obtain social security and auto insurance verification when a claimant's benefits might have covered funeral expenses paid by the board.	2,800	2,800

Claim Sample Number	Criteria	Error Made by the Board	Total Amount Paid	Amount Potentially Overpaid
	Section 13966 of the Government Code entitles the State to a claim on amounts recovered by the victim in the future.	The board did not file a claim against future recoveries in a possible civil action.		
92*	Section 13962 of the Government Code authorizes the board to obtain verification of the costs of medical treatments received by the victim.	The claim specialist did not obtain medical insurance verification when a claimant's benefits might have covered medical expenses.	17,222	$16,139
93	Section 13962 of the Government Code authorizes the board to obtain verification of the costs of medical treatments received by the victim.	The claim specialist did not obtain proper medical verification for medical expenses paid by the board.	578	83
			$36,987	$30,303

Error Rate - 16%

* A related claim to this claim appears on Table 6. The related claim was part of the sample and was also potentially reimbursed in error.

Thirteen of the 81 paid claims in our sample were approved by claim specialists or analysts even though these staff members failed to obtain documentation and verification required by the board's Verification Training and Reference Manual. We estimate that the board made questionable payments totaling $30,303 for these 13 claims. For example, the board paid one claimant in our sample $2,800 for funeral costs without obtaining from the Social Security Administration a statement of whether the claimant was eligible for a Social Security death benefit or obtaining from the claimant's insurance company a statement of whether the claimant had insurance coverage that might have paid the funeral costs. In another case, the board paid a provider $16,139 for medical expenses without verifying whether the claimant had insurance through her employer.

Without properly verifying claims, the board can make errors when paying claimants. Claimants and providers returned $534,528 in payments to the board between March 25, 1987, and January 29, 1988. We sampled 23 of the 625 payments returned by claimants and providers to the board during this period.

We obtained the claim files for our sample of returned payments to determine why claimants and providers returned these payments. We found that the board overpaid providers or claimants $121,665 on 14 of the 23 claim files that we examined because the board staff processing these claims failed to obtain required documentation and perform required verification of these claims. For example, in one

case, a provider refunded $13,881 to the board because Medi-Cal paid for the same medical services for which the board paid. In this case, the provider reported to the board that a Medi-Cal claim was pending, but the claim specialist verifying the claim failed to obtain a statement from the Medi-Cal program specifying whether it would pay the claim. The Government Code, Section 13965, specifies that the board may authorize a direct payment to a treatment provider equal to the losses for which the victim will not be reimbursed from any other source. Further, the board's Verification Training and Reference Manual identifies Medi-Cal coverage as a type of medical reimbursement.

In another case, a staff analyst approved payment of $10,002 to a hospital based on a phone conversation with the hospital's account representative. Although the board received the hospital's invoice for $1,002, the board overpaid the hospital $9,000 because an analyst approved the payment without comparing the actual invoice with the information he obtained over the phone.

In addition to making overpayments to providers, the results of our test revealed that the board failed to reimburse one claimant a total of $267 that this claimant paid to a medical provider. The claimant was not reimbursed because the board paid the provider for the total cost of the claimant's treatment even though the provider had reported to the board that it had already received $267 from the claimant.

Board Staff Receives Inadequate Supervision

Supervising claim specialists and board managers are not sufficiently reviewing the claim verification performed by claim specialists and analysts to ensure that all eligible claimants are paid the proper amounts and that claims submitted by ineligible claimants are denied. According to the board's executive officer, review by a supervising claim specialist is limited to 25 percent of the claims verified by claim specialists that are less than $3,000, that are recommended for allowance, and that raise no eligibility issues. However, none of the files in our sample of 100 claims contained evidence that a supervising claim specialist reviewed the claims. If a claim is $3,000 or more or if a claim involves specific issues such as victim contribution to the crime, the claim specialist completes the verification of the claim and routes the claim to an analyst for his or her recommendation to pay or deny the claim, thus bypassing the supervising claim specialist. Moreover, analysts do not always notice errors made by claim specialists during the claim verification process. For example, an analyst approved one of the payments to ineligible claimants in our sample. With the exception of claims that an analyst places on the board's discussion agenda, none of the analysts' approval or denial decisions are routinely reviewed by a board manager. According to the board's executive officer, a more effective and extensive review by supervising claim specialists and managers would reduce errors in claim processing.

EMERGENCY AWARDS

We selected a random sample of 58 of the 447 claims for emergency awards processed by board staff and placed on the board's agendas for emergency awards between July 7, 1987, and December 15, 1987. The board paid a total of $22,680 for 35 of the 58 claims for emergency awards that we reviewed and denied the remaining 23 claims for emergency awards.

The Government Code, Section 13961.1, specifies that the emergency award application must contain only the following information: the victim's name, address, and telephone number; a brief description of the crime, the date the crime was reported to law enforcement, and the name and address of the law enforcement agency to which the crime was reported; the name, address, and telephone number of the victim's employer; the loss of income or support to date and an estimate of future loss; and the nature of the injury, the name, address, and telephone number of medical providers, and the cost of medical care. In addition, Section 13961.1 requires the application to include a statement requiring the applicant to repay the excess amount if the victim is denied assistance or if the final award is less than the emergency award. This section also requires the application to include the applicant's signature and a statement that the information is supplied under penalty of perjury. However, current board instructions concerning emergency awards also require board staff to

obtain from the applicant or from other sources crime reports, pay stubs for wage loss claims, and bills for claimed medical, psychotherapy, and burial expenses.

Neither the board's Verification Training and Reference Manual nor the board's current emergency award instructions require board staff to verify with hospitals, physicians, or other interested parties the documentation obtained in support of claims for emergency awards. In fact, the board's current emergency award instructions specify that an emergency award is not "an application in the literal sense; an emergency award is basically an unverified advance on a verified application."

The board overpaid one of the 35 paid emergency awards and improperly denied one of the 23 denials of emergency awards in our sample. In 13 cases, the board made questionable denials of emergency awards because the claim specialists or analysts reviewing the claims could not verify information in support of the application. For example, one claimant in our sample was struck by a hit-and-run driver and suffered a cerebral concussion and head and back injuries. As a result of the crime, the claimant was disabled for one month and was unable to work. Additionally, the claimant specified that she was not receiving any state disability reimbursement at the time that she submitted her claim for an emergency award. Further, the claimant stated that she supported not only herself, but her daughter and mother as well. Although the claimant submitted a recent pay stub and a

disability statement from her physician, the analyst processing the claim for the emergency award recommended that the board deny payment because the claimant's employer would not verify over the phone the claimant's employment. The analyst also recommended that the board deny the emergency award because auto insurance coverage was unknown. However, the claim form specified that the claimant did not have auto insurance. According to an analyst for the board, verification of the victim's claimed expenses in this case reduced the possibility of overpayment. However, the Government Code, Section 13961.1, provides the board with a remedy to recover emergency award overpayments by requiring the victim to reimburse the board for the amount of an emergency award if, upon final disposition of the victim's claim, it is found that the victim is not eligible for assistance.

Another claimant in our sample claimed lost wages and medical expense reimbursement as a result of a rape. The victim could not return to work due to crime-related medical complications and submitted a medical disability statement from her physician. In addition, the claimant only received $50 per week from state disability reimbursement and was experiencing extreme financial hardship. The analyst processing this claim for an emergency award recommended that the board deny the claim because the claimant was getting into her automobile at the time that she was approached by the rapist, and the analyst wanted to wait to pay the claim until she could verify that the claimant's automobile insurance would not pay for the claimant's expenses.

Further, one claimant in our sample was stabbed by an unknown suspect and was disabled for approximately two weeks. The claimant's annual income was approximately $9,400 per year, and the claimant supported himself, his two children, and his mother. Although the claim specialist processing this claim obtained the police report for the incident, verification of the claimant's lost time from work, and the claimant's wage rate, an analyst recommended that the board deny the emergency award because the amount due from the claimant's workers' compensation benefits was still unknown. The claimant's application in this case specified that the claimant needed an emergency award because he was unable to keep up with his expenses for rent and food.

Additionally, a senior claim specialist recommended payment on one claim in our sample of claims for emergency awards without obtaining any documentation to support the claimant's lost wages. We inquired why this application had been approved when other claims with more documentation and verification had been denied. According to a board analyst who reviewed this claim for us, she would not have paid this claim, but she noted that the Government Code allows the board to grant an emergency award based solely on the claim application of the victim. However, neither the board's Verification Training and Reference Manual nor the board's emergency award instructions provide any criteria under which a claim for an emergency award can be paid based solely on information provided on the application. Because this criteria is not available to them, different board staff do not always apply the same criteria when reviewing emergency awards.

CONCLUSION

The State Board of Control is improperly denying claims and making overpayments to ineligible and eligible claimants. In a random sample of 100 regular claims, we found that the board improperly denied 5 claims, paid two ineligible claimants $3,310, overpaid five eligible claimants $507, and underpaid four eligible claimants $3,787. In addition, we estimate that the board made 13 questionable payments totaling $30,303 to claimants and providers because board staff did not always obtain required documentation and verification. In addition, for a random sample of 58 claims for emergency awards, the board improperly denied one of these claims. Further, in 13 cases, the board made questionable denials on claims for emergency awards because it required verification of the applications. As a result of these questionable denials, claimants who may have been eligible for emergency awards may not have received them, and, consequently, may have experienced financial hardship.

RECOMMENDATIONS

To ensure that state law and the verification and decision-making requirements of the State Board of Control are always followed, the board should take the following actions:

- Implement procedures to require a supervising claim specialist to review a greater proportion of the claim specialist's verifications before a claim is routed to an analyst;

- Implement procedures requiring board managers to review at least a random sample of the regular claim approval and denial decisions made by analysts; and

- Implement procedures clarifying the amount of verification necessary on applications for emergency awards.

CHAPTER III

THE STATE BOARD OF CONTROL DOES NOT INFORM CLAIMANTS OF THE REQUIREMENTS FOR QUALIFYING FOR EMERGENCY AWARDS OR FOR APPEALING STAFF DECISIONS

The board does not meet the requirements of the law to explain to claimants how to apply or qualify for emergency awards. As a result, some claimants do not apply or qualify for emergency awards although they have emergency needs resulting from the emergency medical expenses or the loss of income or support. In addition, the board does not inform claimants that, if a claimant disagrees with a staff decision and requests the board to review the staff recommendation, the board will not review the claimant's individual case unless the claimant asks to be heard and appears in person at a board meeting. Consequently, claimants who disagree with staff decisions often do not receive board hearings even though the staff decisions may have been in error. The board is currently revising its application to clearly explain to claimants how to apply and qualify for emergency awards.

INSUFFICIENT INFORMATION ABOUT QUALIFICATION

Section 13961 (b) of the Government Code requires the board to provide claimants with applications for assistance that explain who is eligible, what kind of assistance is available, and how the board evaluates a claim. In addition, Section 13961.1 (a) of the Government Code states that the board should make emergency awards available to

claimants who have emergency needs resulting from loss of income or support or who require emergency medical expenses as a result of a crime.

Despite those requirements, the board's application for assistance does not clearly explain the application process or the qualifying requirements for an emergency award. For example, the application does not ask whether a claimant has a need for emergency assistance. In addition, the only space on the application where a claimant could express a need for emergency assistance is in the "Additional Information and Comments" section for which the instructions state: "This space is provided for you to give us any information that will assist in the speedy processing of your claim . . .it's to your advantage to help us all that you can!" However, the claimants receive no information as to what would "help" the board to grant them emergency awards.

Claim specialist supervisors, who initially review applications, consider for emergency awards only those applications that have the "e" circled in a box labeled "For Board of Control Only." Not only does the application not indicate that the "e" means emergency application, but it also instructs claimants <u>not</u> to write in that box. Consequently, a claimant cannot know how to communicate the need for emergency assistance to the claim specialist.

According to the executive officer, the application does not clearly explain how to apply for an emergency award because the board originally had two applications--one for emergency awards and one for nonemergency claims. However, when the board combined the applications, the board deleted essential information about applying for an emergency award.

We reviewed 100 claims for nonemergency awards and identified two eligible claimants who did not receive prompt assistance although they may have qualified for emergency awards because of a loss of support or emergency medical expenses. For example, a father of three children was killed by a hit and run driver on September 13, 1986. Two days later, his widow applied for assistance. Although the family income was only $381 a month after the incident, the family did not receive any money from the board until July 14, 1987, more than ten months after the widow had submitted her claim.

APPEAL OF DECISIONS

According to Sections 13963 and 13964 of the Government Code, at hearings, the board must review each claim and make a decision to approve or deny the claim. However, the board has unofficially delegated most of this review and decision-making process to its staff. At the hearing, the staff members present their recommendations on claims to the board, and unless the claimants appear before the board to appeal the staff recommendations, the board adopts the staff

recommendations on the consent agenda. For each claim on the consent agenda, the board accepts the staff recommendation without reviewing the file or discussing the claim. Ninety-one percent of the claims that the board approves or denies are on the consent agenda.

Before the hearing, staff members notify the claimants of the staff recommendations. If a claimant disagrees with a staff recommendation, the claimant may return the board's notification letter with a listing of the claimant's reasons for disagreeing with the recommendation. Although the letter states that the applicant may appear at a hearing of the board, it does not inform the claimant that the board members will not discuss the claim or even be informed of the claimant's disagreement unless the claimant asks to be heard and appears in person at the board hearing.

Further, if a claimant disagrees with the staff recommendation, board policy dictates that staff members will contact the claimant and schedule a claim for the discuss agenda only if the claimant asks specifically to be heard by the board. However, even if the claim is placed on the discuss agenda, the board will accept the staff recommendation without review or discussion unless the claimant appears at the hearing. According to the executive officer, because of the volume of claims paid or denied, the board cannot review each file for every claim.

In our sample of 100 claims we found one instance when a claimant had disagreed with the staff recommendation for denial because she had received from a local agency erroneous information about how to complete the application. However, the staff did not place her claim on the board's discuss agenda. Consequently, the board did not discuss or review the claim and the claim was denied. Moreover, we determined that the staff had inappropriately denied this claim.

Corrective Action

The board is redesigning the claim application. According to the executive officer, the new form will specifically explain to the claimant the process for applying and qualifying for an emergency award.

CONCLUSION

Because the board does not explain to claimants the process for applying and qualifying for emergency awards, some claimants who should receive emergency awards do not apply or qualify and, consequently, either do not receive emergency assistance or do not receive it promptly. In addition, the law requires that the board review each claim; however, because of the volume of claims paid or denied, the board has delegated this process to staff members. Finally, staff

members do not inform claimants that they must ask for a hearing and appear in person before the board if they wish to appeal staff recommendations.

RECOMMENDATIONS

To ensure that claimants receive necessary information for receiving emergency awards or appealing board decisions, the board should take the following actions:

- Revise the application to clearly describe how an applicant can apply and qualify for an emergency award and to explain the procedure that the board follows in evaluating eligibility; and

- Advise claimants of their right to appeal board and staff decisions.

The Legislature and the Governor should enact legislation that establishes an appeal process at the staff level to ensure that claimants have a hearing if they disagree with staff recommendations.

CHAPTER IV

THE STATE BOARD OF CONTROL NEEDS TO IMPROVE ITS INTERNAL CONTROLS AND MAKE BETTER USE OF ITS AUTOMATED SYSTEM

The board needs to improve its internal controls over payments to claimants and providers. Specifically, the board has poor internal control over the payments to claimants and providers that are made from the board's automated tape. For example, the board does not confirm that payment clerks enter names and payment amounts correctly onto the tape. As a result, the board made erroneous payments totaling $10,332 to the wrong people. In addition, the board's automated system does not identify and prevent payments that exceed the amount allowed by law. Further, the board does not use its automated system effectively. For example, the board paid local agencies $406,380 for 5,073 claims in fiscal year 1986-87; however, the board does not keep a record of the number of claims that each local agency verifies for the board. Consequently, when a local agency requests payment for verifying a number of claims, the board cannot ascertain that it received that number of verified claims.

The Office of Management Planning and Technology of the Department of General Services identified deficiencies in the board's internal control over its automated file system. As a result of that audit, the board has developed a plan to correct the problems in internal control.

INTERNAL CONTROLS

Section 13403 of the Government Code requires state agencies to provide the internal controls necessary to safeguard state assets. In addition, Section 4846.5 of the State Administrative Manual states that no single employee shall be allowed complete control over all important stages of a transaction that affects essential data. Without a separation of duties and without restricted access to automated files, the risk increases that staff members will make errors and unauthorized payments.

The board has insufficient control over the payments that are made from the automated tape that the board uses for issuing payments to claimants and providers. To pay claimants and providers, the board's payment staff enter onto the board's automated payment tape the provider's name and address and the payment amount, which the staff obtain from the report of reimbursable costs. The State Controller's Office then uses the automated tape to write and issue checks to claimants and providers. However, no one compares the names and amounts on the payments that the State Controller's Office issues to the information on the report for reimbursable costs.

We reviewed 100 claims and found one authorized payment that the board did not pay because payment staff did not enter the name or amount on the payment tape. Further, in our review of 23 payments returned to the board between March 25, 1987, and January 29, 1988, we

found errors made by the payment staff that resulted in three payments totaling $10,332 to the wrong people. For example, the board paid $2,800 to the victim of a murder for her funeral costs instead of paying her uncle who paid these costs. In addition, because the board does not monitor the entries made on the payment tape, members of the payment staff can make undetected unauthorized payments. Further the employee who reconciles the total payments authorized by the board to the total dollars paid to the claimants may also make unauthorized changes to names and amounts on the payment tape. As a result of this audit, the executive officer no longer allows the person reconciling the payment files to make entries onto the payment tape.

The board's executive officer agrees that the board needs to improve its internal controls over payments to claimants and providers. In addition, the board is in the process of hiring a staff person to design and implement a system of internal controls over claim payments.

Excessive Payments

The board's automated system does not identify and prevent payments that exceed the amount allowed by law. The law limits regular claims to $23,000 unless federal funds are available, in which case, the total maximum award may be increased to $46,000. Also, the law limits emergency awards to $1,000 and attorneys' fees to a total of $500 per claim or 10 percent of the amount of the payment, whichever is

less. In our review of 58 claims for emergency awards, the board overpaid one emergency award by $533. In addition, we obtained a list of payments that the board made to one attorney and found an overpayment of $47.

According to the executive officer, when the system was designed, staff members did not have enough expertise to determine all of the controls that the system should have. However, the board is modifying the system to ensure that claimants and attorneys do not receive more than the law allows.

Duplicate Payments

Section 8422.1 of the State Administrative Manual requires that state agencies determine before payment that the State Controller's Office has not previously paid an invoice. Without such a procedure, the board can pay claimants or providers twice for the same claim. However, the board's automated file system does not contain sufficient information to determine whether the board already has paid a provider or claimant for a particular expense. The claim file contains the information necessary to check for previous payments, including the provider's or claimant's name, social security number, date of birth, the type of expense, and the date of service, but the board does not enter all of this information from the claim file into the automated files. As a result, the board cannot rely on the automated files to determine whether a payment has already been made.

In our review of 23 payments returned between March 25, 1987, and January 29, 1988, we noted that the board paid each of 11 providers twice. These duplicate payments, which the system did not detect and prevent, totaled $14,571.

According to the executive officer, when the staff members designed the automated file system, they did not have enough expertise to design a system with all of the control elements. However, the board is in the process of developing a system to identify duplicate payments.

Payments to Local Agencies

The board does not include all of the necessary information in its automated files to monitor payments to local agencies. Local agencies help victims to file claims for assistance with the board, and the board contracts with some of these local agencies to verify the information in the claims. Some local agencies also verify claims for additional awards. The local agencies then submit invoices to the board requesting payment for verifying claims. During fiscal year 1986-87, the board paid local agencies $406,380 to verify 2,524 regular claims and 2,549 additional awards.

When the board initially receives the regular claims, it records enough information in its automated files to determine the number of regular claims that each agency verified. The board should

then be able to match the number of those claims in its automated files to the number of verified regular claims on the invoices from each agency. According to the executive officer, the board reviewed the number of regular claims that the local agencies had submitted during fiscal year 1986-87. However, the staff members could not provide the documents that they had used to conduct this review, so we were unable to confirm this.

Although the board records sufficient information in its automated files to determine the number of regular claims that each agency verified, it does not record this information for the additional awards. As a result, when a local agency later submits to the board an invoice requesting payment for verifying claims, the board cannot confirm that the invoices accurately reflect the number of additional awards that the local agency verified.

Finally, in our review of 105 invoices that local agencies had submitted to the board, we found that 3 did not include the number of claims that the agency had verified. When the invoices do not include this number, the board cannot confirm the accuracy of the invoice. Without this confirmation, the board may be paying agencies for work that the agencies did not perform.

According to the executive officer, the board has hired a staff manager who is responsible for developing a system to confirm that the invoices from local agencies are accurate.

Department of General Services' Audit

The Office of Management Technology and Planning of the Department of General Services issued an audit report of the board's automated file system in November 1987. The department concluded that the system does not have sufficient internal control to ensure that the information in the files is accurate or protected. The system lacks basic controls over the information contained in the files, and it lacks sufficient detail to provide staff members with the information that they need to make program decisions.

Corrective Action

The board, as a result of the Department of General Services' audit, has developed a plan to correct the internal control deficiencies identified in the audit. The board estimates that it will complete and implement the plan by December 1988.

CONCLUSION

The board needs to improve its internal controls over payments to claimants and providers. Specifically, the board has poor controls over payments that it makes from the automated files to prevent staff from making undetected or unauthorized payments. In addition, the automated payment system does not identify and prevent payments that exceed the amounts allowed

by law. Further, the board does not enter the necessary information into the automated files to check for duplicate payments to claimants or providers or to monitor additional awards verified by local agencies. Finally, the board does not use the information available in the system to confirm that requests for payment from local agencies are correct.

The Office of Management Planning and Technology of the Department of General Services also identified significant deficiencies in the board's internal control over its automated file system. As a result of that audit, the board has developed a plan to correct the internal control deficiencies.

RECOMMENDATIONS

To ensure that staff make only authorized payments and to ensure that the board's automated files contain essential information, the board should establish the following procedures:

- Require that a staff member who cannot authorize or enter payment information reconcile actual check amounts and payees to the payments authorized;

- Design the automated file system to identify and prevent payments to claimants and attorneys exceeding the amount allowed by law;

- Enter the necessary information in the automated system to determine whether a claimant or provider has been paid for an expense;

- Require that staff members use the automated files to keep a record of the verified claims that it receives from each local agency; and

- Continue to implement the plan of action that the board had developed to correct the internal control deficiencies identified by the Office of Management and Technology of the Department of General Services.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

Date: March 14, 1988

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APPENDIX A

THE NUMBER OF CLAIMS RECEIVED
AND THE NUMBER OF CLAIMS PROCESSED
FISCAL YEAR 1982-83 THROUGH FISCAL YEAR 1986-87
(From Unaudited Documents of the State Board of Control)

	Fiscal Year				
	1982-83	1983-84	1984-85	1985-86	1986-87
Claims Received					
Regular awards	8,600	10,700	13,165	11,990	19,562
Additional awards	1,539	2,052	1,500	3,842*	12,689*
Total Received	10,139	12,752	14,665	15,832	32,251
Claims Processed					
Paid	7,741	8,715	7,231	16,571	14,776
Denied	4,444	2,910	3,466	3,674	2,459
Total Processed	12,185	11,625	10,697	20,245	17,235

* These are estimated figures.

THE STATE BOARD OF CONTROL
THE NUMBER OF REGULAR CLAIMS PAID, DENIED, AND PENDING
JANUARY 1987 THROUGH JANUARY 1988

We reviewed the State Board of Control's records of regular claims paid, denied, and pending from January 1987 through January 1988. We found that the board received 6,081 more claims than it paid or denied during this period. While the following table shows the number of regular claims paid, denied, and pending during this period, it does not show all the claims that the board has not fully processed. According to the executive officer, as of January 10, 1988, staff had 9,648 claims awaiting review and an additional 5,399 claims in process.

	1987												1988
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
Beginning Balance Regular claims pending	*	224	283	460	1,012	1,749	2,310	2,913	3,357	4,379	4,878	4,899	5,747
Regular claims received by board**	1,685	1,354	1,847	1,769	1,784	1,769	1,575	1,794	1,640	1,615	1,715	1,430	1,379
Subtotal	1,685	1,578	2,130	2,229	2,796	3,518	3,885	4,707	4,997	5,994	6,593	6,329	7,126
Less regular claims paid or denied by board	1,461	1,295	1,670	1,217	1,047	1,208	972	1,350	618	1,116	1,694	582	1,045
Ending Balance Regular claims pending	224	283	460	1,012	1,749	2,310	2,913	3,357	4,379	4,878	4,899	5,747	6,081

* The number of claims pending at January 1, 1987, was not available.

** We obtained these unaudited figures from the State Board of Control.

STATE OF CALIFORNIA GEORGE DEUKMEJIAN, *Governor*

STATE BOARD OF CONTROL
P.O. BOX 3035
SACRAMENTO, CA 95812-3035

March 10, 1988

Thomas W. Hayes, Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for providing us the opportunity to review and comment upon the draft of your report, entitled "A Review of the State Board of Control's Victims of Crime Program."

We wish to express our appreciation for the professional manner in which your staff conducted the audit. We also appreciate your acknowledgment of the progress that the State Board of Control (Board) and its staff have made in taking corrective actions to date and in future planning to rectify procedures. We wish to state categorically that the Board of Control is addressing all the issues in your report and will mobilize all required resources to correct the problems we have been experiencing in a timely fashion.

Your draft report addresses four major areas: 1) the promptness with which the Board processes victims' claims, 2) the accuracy of the Board's verification of victims' claims, 3) the effectiveness of the Board's efforts to inform claimants regarding the filing of emergency award requests and the appeal of staff recommendations, and 4) the extent to which the Board maintains proper internal controls over award payments and makes the best use of its automated system.

We can assure you unequivocally that we will attain our goal of a 90 day average claims processing time within the next few months. We will correct all problem areas in an efficient and effective manner.

We are drawing upon resources of the State to take corrective action as described below. We have obtained specialists from various departments within the Administration with specialized skills and expertise to assist in the review of our statutes and regulations, to develop new systems and forms, to write detailed processing procedures, and to automate the entire program.

1) Promptness in Paying or Denying Claims

The Board of Control has experienced tremendous growth in the number of claims received which has resulted in claims not being paid or denied as promptly as the law requires. In order to address this problem, the following steps have already been taken.

- We have instituted an overtime program, which will continue until our processing goals are reached.

- We are reclassifying 23 vacant clerical positions to Claims Specialist, and expect to fill the positions and begin training by March 21, 1988. In total, we will hire 27 new claims specialists, and have all other position vacancies filled in the Victims Program, by the end of March 1988.

- Since your staff completed their review, we have executed 15 Joint Powers Authority agreements with local agencies that verify claims and have 9 other JPAs in process.

- We have designed an eligibility checklist and review procedure for determining what constitutes a "completed" claim application. This procedure, which is now in effect, involves the immediate issuance of necessary verification forms that previously were not sent promptly.

In addition, the following corrective actions are being taken:

- A major staff reorganization which will include crime-category based verification teams; intensive supervisory review of staff recommendations; and a multi-level claim approval process which will not directly involve the claims analysts.

- Redesign of documents to ensure that they give clear instructions to enable claimants to secure efficient processing of their claims.

- Determination of the legality and feasibility of the Board delegating to the staff limited authority to approve or deny emergency awards, hear claims, and make payments.

Again, let me reiterate that we have every confidence that the steps being taken to achieve prompt claims processing will be effective in the very near future in allowing us to attain our goal of a 90 day average claim processing time.

2) Accuracy in Denying, Paying, and Verifying Claims

Once again, as a result of the unprecedented growth in the number of claims filed with the Board, we have experienced a heavy workload in the area of verification which impacted overall accuracy. Therefore, the following steps have already been taken:

- We have developed a list of issues the staff will use to propose new Board policies and guidelines, to ensure our staff and the local contract agencies process claims in a legally appropriate and consistent manner. To assist in this effort, a staff member has been assigned full-time to coordinate all policy issue development activities.

- We are reclassifying four existing positions to Claims Specialist Supervisor, and are scheduled to fill the positions by April 1, 1988. By increasing the number of supervisors of the verification staff, we will increase the frequency and effectiveness of the claims review process.

- Our planned staff reorganization (described above) will include a process by which claim verification and analysis activities will be reviewed extensively by supervisors and managers.

- We are evaluating the emergency award process to ensure that the staff conducts a proper and timely review of these requests as required by law.

We assure you that these efforts will increase accuracy and accelerate the payment process dramatically.

3) Informing Claimants Regarding Emergency Awards and the Appeal of Staff Decisions

We acknowledge that claimants have not always received adequate information regarding emergency award requests and the method of appeal of staff recommendations. The revision of the claim application procedure will include an evaluation of the process by which an applicant can apply and qualify for an emergency award. The result of this evaluation may be the design of a separate emergency award request form, or clear instructions added on the regular application form for requesting an emergency award.

As a result of your finding, the staff will investigate the effectiveness of notices sent to claimants, advising them of the staff's recommendation on their claim.

The Board is committed to providing claimants with clear, timely information regarding how staff recommendations can be appealed. These notices will also be revised to reflect any changes to the claim review and recommendation process that result from our reorganization.

4) Improving Internal Controls and the Automated Payment System

We acknowledge the need to improve the Board's internal controls over payments, and to make better use of our automated payment system. The Board has been aware of these deficiencies since November 1987, when it received the audit by the Department of General Services. In response to that audit, we developed an action plan to address the deficiencies in internal controls and in our automated payment system.

To date, the Board has made significant progress in meeting the goals of the action plan. In particular, the Board has designed and partially implemented an automated system for identifying and collecting emergency award overpayments. This effort will be expanded to create a fraud detection and recovery function for addressing any identified overpayments.

The Board is currently establishing a Random Audit Control Unit in the Victims Program to design and implement a broad range of necessary fiscal controls. We have received approval from the Office of Information Technology of a Feasibility Study Report for transfer of our EDP mainframe to the Health and Welfare Data Center. This will enable us to complete development of EDP design and compatible software which will provide on line access to claims processing and JPA auxiliary locations and will enhance the security of the system and services to the Victims of Crime Program.

The Board appointed a new Executive Officer less than seven months ago. Since joining the Board, he has been evaluating the efficiency and effectiveness of the entire Board operation; is proposing new Board policies in areas needing clarification; developing new procedures to streamline the claims-processing operation in the Victims Program; and is implementing internal controls to ensure fiscal integrity.

By taking the actions as outlined herein, we are confident that the Board and staff can significantly improve the operation of the Victims Program. Specifically, we expect to achieve the 90-day average claims processing time, and continue to improve the quality of services provided to victims and their representatives.

In summary, the rapid growth of claims in the Victims Program has created administrative and management concerns which you describe and we acknowledge. Be assured that we are mobilizing all resources to correct these concerns as quickly as possible.

Again, we appreciate the opportunity to respond to your draft report. If you have any questions concerning this response, you may wish to have your staff contact Austin Eaton, Executive Officer, State Board of Control, at (916) 445-1540.

W. J. ANTHONY, Chairman
State Board of Control

cc: Dr. Elmer T. Jaffe, Member, State Board of Control
Robert Shuman, State Controller's Office
Austin Eaton, Executive Officer, State Board of Control

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps